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# Managing health care in Australia: Steps on the health care roundabout?

Peter Harvey

Sharing Health Care SA Project, University of South Australia

This paper explores some of the lessons of the coordinated care trials in Australia in the context of managed care in America and asks how do we best manage our finite health care dollars for the most equitable and effective outcomes for whole populations?

The COAG trial in Australia tested a more structured process for managing the care of patients with chronic illness and postulated that currently fragmented health system funding could be pooled around individual patient need, and managed for improved economic outcomes and patient wellbeing. There is little doubt, following this initiative and much work in other countries, that as health care costs rise, for a range of reasons, improvements are needed in the management of our resources if we are to control rising health care costs. We also know that chronic illness, much of which is preventable and avoidable, is the major component in the rising health care cost equation and a factor likely to consume around 75% of our health dollars in the future. Much chronic illness can be prevented through social and population health strategies and we know that even if chronic illness can't be prevented, it can be managed better through community-based chronic illness management programs. These programs rely on information, education, patient lifestyle and behaviour change, and on patients developing improved self-management skills. But, what is the best way to manage population health in Australia and ensure equity and fairness in the health care market as we evolve new approaches, especially to the management of chronic illness?

**Key words:** Chronic Illness Management, Prevention, Improved Wellbeing, Resource Efficiency

Australia is faced with the same burgeoning demand for health care services as most western nations (Grey, 1998, p907). The combination of an ageing population, increasingly informed and demanding consumers (Enthoven, 2000, p103; Mechanic, 2001b, p38) and ever more complex and sophisticated systems of care is driving up the demand for and cost of health care. In this context the debate is about whether market driven management systems, government run schemes, or a two-tiered system combining both will be the best way of delivering improved financial efficiencies along with improved population health outcomes within an essentially rationed and capped health care system.

We have also found, increasingly, that our populations are suffering from many debilitating forms of illness that cannot be treated effectively once illness progresses to acute stages, and that, in the main, many of these conditions have social and environmental antecedents that are preventable (Baum, 1998; Glasgow, Orleans, & Wagner, 2001, p 586). Much of the debilitating illness currently afflicting our communities need not occur at all and the impact of the illness that does occur can be

moderated significantly to improve patient wellbeing and quality of life (Telford, Reid, Vickery, & Fries, 2000; Leventhal, Prohaska, & Hirschman, 1985, p227).

These key observations are now combining to inform strategies for overcoming the current crises. We are increasingly relying on and investing in population-based strategies. Initiatives such as the Council of Australian Governments (COAG) Coordinated Care Trials, the Enhanced Primary Care (EPC) program and the more recent Chronic Disease Self-Management program (CDSM) have been designed to improve the general management of chronic illness in the community and to reduce the impact and incidence of such illnesses in the future through education and preventive primary health models of care.

Health care agreements now include conditions which facilitate the substitution of state hospital funds and Commonwealth medical and pharmaceutical funds where better health outcomes or efficiency gains can be demonstrated. This has fostered coordinated care arrangements, especially for those with chronic health problems (Podger, 1999, p112; Scott, 2001, p98).

Data on compliance or adherence to best practice approaches to care, both clinical and

lifestyle related, suggest that it is no longer a matter of knowing what to do about these problems, but of knowing how to do more effectively what we know we can and should be doing (Colquhoun, 2002). That is, we now need research effort in the areas of behaviour management and systems implementation that will inform us about the best ways to ensure compliance to treatment and management—for those with confirmed chronic illness, for example—and compliance to positive lifestyle elements such as diet, exercise, and lifestyle improvements for healthy individuals in the community who may be at risk of future chronic illness.

We have shown through the coordinated care venture that more effective use of pooled and integrated health care funding is possible and that health outcome improvements can be achieved through better coordination and planning of health service delivery (Commonwealth of Australia, 2001a; 2001b). Reductions in duplication of services, sharing of relevant information between providers, and simple scheduling and recall systems to ensure optimum care for patients all contribute to better outcomes and to improved efficiencies across the system (Glasgow et al., 2001).

The Commonwealth Government now funds health assessments for the aged, care planning, pharmacy reviews, and case conferences for patients with chronic conditions, and is currently testing new forms of systems integration in rural communities through the Regional Health Service Program. In addition, major initiatives in chronic disease self-management are also being funded on the premise that improved community-based education and support programs will teach people how to manage their care better and result in improved wellbeing for people with chronic illness (Fries et al., 1993; Fries, 2000; Fries, Singh et al., 1994; Fries, Harrington et al., 1994; Fries, 1997; Fries, Koop, Sokolov, Carson, & Wright, 1998; Fries & McShane, 1998; Holman & Lorig, 2000; Lorig, Gonzales, & Laurent, 1998; Lorig, Mazonson, & Holman, 1993; Lorig et al., 1996; Telford, Reid, Vickery & Fries, 2000; Vita, Hubert, & Fries, 1997).

This work is leading to the idea that a more effective way of managing chronic illness in particular is to manage the antecedents of it, or at least to manage the effects of it before these effects translate into acute crises, emergency admissions, and unplanned demand for acute health care. We

are also discovering through examination of health care systems overseas that, increasingly, governments are becoming involved in managing the overall pool of health care resources in order to moderate both supply side and demand side cost escalation. The myth that private management of health care is more effective than other models is being tempered with the idea that, for the benefit of whole communities and for improved equity of access to care, governments must maintain a central function in the distribution and allocation of health system funding. Indeed, to avoid unproductive cost shifting, such involvement is essential (Grey, 1998, p917).

Given the high cost of managing private funds compared with public management (up to 20% of available resources are consumed by management costs), and accepting that we need to ensure that the largest possible proportion of available funds actually goes into service provision and patient care, universal health care systems are being promoted (Grey, 1998, p910; Light, 1999, p689; Mechanic, 2001a, p474). Even from an ethical position, the problem of universal access must be solved before we can properly address issues of equity and justice in relation to the provision of health care services (Buchanan, 1998, p633). Nowhere is this more obvious than in the US where over 40 million patients are denied access to comprehensive health services (Ferlie & Shortell, 2001, p303), other than basic emergency care, on account of their lack of insurance, and a further 20 million are radically under-insured (Buchanan, 1998).

The evidence strongly suggests, then, that if costs are to be controlled and if conditions of optimal access are to be achieved, the role of government needs to be extended. The evidence also suggests that reasonable access depends on rejecting user charges as a cost control measure (Grey, 1998, p918).

In addition, a key part of the solution to rising health care demand is increasingly being seen as community-based education programs that help people to manage their lives before the lack of life management lands them in the acute sector with nowhere to go and with no chance of mediation. That is, like the Americans who developed managed care, we are conscious that we cannot leave the management of our combined health care resources to chance, we have to begin to view the

population's demand for health services and the way we meet and manage this demand as a complex "whole of population" management problem with no element existing in isolation from others.

We are also coming to recognise, in the context of whole population health management and service integration, (Scott, 2001, p103), that such a view of population health and wellbeing must rest upon the fundamental premise of a universal health care system (Mechanic, 2001b, p50). Such a system will safeguard against cost shifting while ensuring the available health care resources are distributed equitably across the community for the benefit of whole populations (Light, 1999, p689).

### Opportunities

Recent reports on fund holding and fund management systems for health care delivery (Del Fante, 2001; King & Wilson, 2001) have highlighted the need for and the opportunities around new mechanisms for funding and delivering primary care services in Australia. Clearly the funders of health service provision are interested in improving efficiencies across the system as demand grows and becomes more complex. One important strategy for such a model or management structure is the integration of hitherto disparate and competing avenues of health service funding to provide flexible fund pools (Podger, 1999) at the local level which will enable communities to allocate resources to meet their local priorities and to address community needs at this local level.

A recent review for the New Zealand Treasury and Ministry of Health echoes other literature in the health reform field when it asserts that:

*Primary health care has become an important policy priority in the health systems of most countries... (It is seen to be) a key strategy in resolving major health service problems such as poor access, inequalities in health status, rising costs, and failure to develop community participation.*

Countries such as New Zealand and the United Kingdom are among those making changes to the structural arrangements for primary care (e.g.,

encouraging Independent Practitioner Associations (IPAs) in New Zealand and establishing Primary Care Groups (PCGs) in the UK to maximise the quality and effectiveness of the sector (King & Wilson, 2001, p20).

### Next Steps

With the advent of the numerous primary health care initiatives being established across Australia, including the new Commonwealth Regional Health Services (CRHS) designed to enable small rural communities to integrate their primary health care services across clusters of small health units, opportunities are emerging for communities to pool and manage their resources differently. In addition, the care planning and practice incentive programs for GPs are encouraging GPs to package services to patients with chronic illness in particular, with a view, no doubt, to future fund holding arrangements that will transcend the existing piecemeal MBS fee for service process and lead to more integrated care at the local level.

It is likely that teams of GPs, allied health providers and Regional Health Service clusters will, in the future, see the wisdom of working together to achieve the common goal of improved community health and wellbeing outcomes through a growing emphasis on consumer participation (PricewaterhouseCoopers, 2002). GPs are already (in some areas at least) increasingly establishing formal working arrangements between their practices, their own practice staff and allied health teams. As the incentives driven by the Commonwealth increasingly reinforce such integration, practitioners will see the business sense in such team approaches. Also, with IT systems becoming increasingly sophisticated, and as we overcome some of the early teething problems associated with patient confidentiality and patient record systems and the ability of providers to collaborate meaningfully around the integration and provision of patient care, we face the real prospect of new and creative funding arrangements across the health care spectrum which will serve to change the face of primary care in Australia.

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## Correspondence to:

Peter Harvey  
Sharing Health Care SA Project  
University of South Australia  
Nicolson Avenue  
Whyalla Norrie SA 5608  
AUSTRALIA  
email: peter.harvey@unisa.edu.au